

# APPLICATION TO PROVIDE AGENCY COMPANION SERVICES

The Community Long Term Care (CLTC) Program contracts with qualified providers to provide Companion services to Medicaid recipients. These services are prior authorized by CLTC case managers and nurses. The authorization includes the number of hours of service per week, the days the service is to be provided and the hours each day. Contracting as a provider of companion services allows the provider to serve the following groups:

- Community Choices Waiver Participants;
- HIV/AIDS Waiver Participants;
- South Carolina Choice Waiver Participants;

The hourly reimbursement rate is indicated below:

- Agency Companion: \$9.00

Providers must follow the Scopes of Services for this service as well as meeting all other contractual obligations. The Scope of Services can be found on this web site. You should print a copy to review before completing this application.

Each client is required to choose a provider from a CLIENT CHOICE OF PROVIDER FORM that lists all CLTC providers in the area by county. Because of the client choice of provider policy we cannot guarantee the number of CLTC clients any provider will be authorized to serve. Therefore, we urge all providers not to rely upon Medicaid as the primary source for reimbursement. **Business decisions should not be made based on any agency's or individual's anticipation of receiving any referrals from CLTC.**

In order to complete an application, print this document. Check the appropriate boxes and fill in the information that is requested. You must also include the items listed in addition to completing this application.

Applications should be sent to: **Division of Community Long Term Care- Waiver Management, Post Office Box 8206, Columbia, SC 29202-8206, Attention: Chaini Demas.** If you have any questions regarding this process or the stated requirements, please call Chaini Demas or Tony Matthews at (803) 898-2590.

**The following items must checked and/or enclosed for this application to be considered for processing:**

I wish to become a provider of companion services: (Check below)

- ☐ Agency Companion
- ☐ I understand that It will be necessary to schedule a DHHS compliance review visit as part of the contracting process and that I will be contacted prior to this visit.
- ☐ I agree to abide by all requirements and policies of the Department of Health and Human Services as described in my contract and any other communication received from DHHS.
- ☐ I certify that neither I, nor any officer, director, administrator, billing agent, managing employee, affiliated person or partner, or shareholder having an ownership interest has been involuntarily terminated or has involuntarily withdrawn from participation in the CLTC Program within the last three (3) years.
- ☐ By checking this box I am indicating that my agency requires Medicaid participants to sign agreements. (Leave blank if this is not the case.) I understand that I must include copies of all agreements with this provider application.
- ☐ I certify that this agency has written bylaws or the equivalent, which is a set of rules adopted by the provider agency for governing the agency's operations.
- ☐ I certify that this agency will submit any subcontracts to DHHS for prior approval.
- ☐ I certify that a governing body or person(s) so functioning shall assume full legal authority for the operation of the provider agency.
- ☐ My regularly scheduled holidays are listed on the attached sheet.
- ☐ The county or counties in which my agency plans to provide services are listed on the attached sheet:
- ☐ I understand that this agency may be reviewed by DHHS at any time during normal business hours. This review can be announced or unannounced. I also understand that my agency must produce all requested records related to the administration of the agency, staff records and individual client records.
- ☐ I understand that persons providing in-home services and supervisors must use the Care Call system to document their service delivery and adherence to this contract.
- ☐ I understand that I must abide by all marketing limitations as indicated in the contract.
- ☐ I understand that I must not give any type of gifts, samples or other products to CLTC case managers or other CLTC employees.

☐ I understand that my staff must report incidents of abuse, neglect or exploitation of adult beneficiaries in accordance with the Omnibus Adult Protection Act (S.C. Code of Laws Section 43-35-5, et seq.).

☐ I understand that I will be required to attend a training session at SCDHHS prior to the initiation of a contract.

The name of the person who will sign the contract: \_\_\_\_\_

The name of the person designated to serve as the agency administrator: \_\_\_\_\_

The following items must be submitted with your application:

- You must submit certified evidence of operating capital that will show that the provider agency has the capability to operate for a minimum of 60 days in the event Medicaid reimbursement is delayed or withheld for any reason. This must be a written statement from an officer of a financial institution or a certified accountant.
- Documentation that demonstrates experience, i.e., written references, established agency verification, etc., in providing Companion or a similar service.
- A copy of your organizational chart that includes the names of persons in any management or ownership capacity. (See attached form)
- A copy of the provider agency's Workers' Compensation Insurance Policy or an explanation why this is not needed. If you do not yet have one, please indicate on your application. A copy of the policy must be presented prior to the provision of services.
- A copy or letter of certification of the provider agency's current liability insurance Policy showing coverage to include date of application.
- A copy of your articles of incorporation or other document that established you as a legal entity. If you do not already have this, it must be obtained from the Secretary of State.
- A completed Pre-contractual Information Form. (See attached form)

The following items must be brought to your scheduled training session:

- Your company's policy and procedure manual
- Infectious disease program
- In-service program - should include topics that will be used for in-service hours
- Mock employee and participant chart

I certify that all information given with this application is true. I understand that any false information will result in this application being denied.

\_\_\_\_\_  
**Applicant's signature**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Date**

**Agency Telephone Number** \_\_\_\_\_

**Agency address** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Email address:** \_\_\_\_\_

## List of Scheduled Holidays

Check each holiday observed by your agency and indicate additional holidays below.

- ☐ New Year's Day
- ☐ Martin Luther King's Birthday
- ☐ Presidents Day
- ☐ Good Friday
- ☐ Easter
- ☐ Memorial Day
- ☐ Independence Day (July 4<sup>th</sup> or day observed)
- ☐ Labor Day
- ☐ Veterans Day
- ☐ Thanksgiving
- ☐ Day after Thanksgiving
- ☐ Christmas Eve
- ☐ Christmas
- ☐ Day after Christmas

List additional holidays here:

---

---

## Counties Served

Put a check next to every county in which you intend to provide services. Remember that you must be able to demonstrate that you have a nurse close enough to the county to meet the geographical scope requirements.

<input type="checkbox"/>	Abbeville
<input type="checkbox"/>	Aiken
<input type="checkbox"/>	Allendale
<input type="checkbox"/>	Anderson
<input type="checkbox"/>	Bamberg
<input type="checkbox"/>	Barnwell
<input type="checkbox"/>	Beaufort
<input type="checkbox"/>	Berkeley
<input type="checkbox"/>	Calhoun
<input type="checkbox"/>	Charleston
<input type="checkbox"/>	Cherokee
<input type="checkbox"/>	Chester
<input type="checkbox"/>	Chesterfield
<input type="checkbox"/>	Clarendon
<input type="checkbox"/>	Colleton
<input type="checkbox"/>	Darlington
<input type="checkbox"/>	Dillon
<input type="checkbox"/>	Dorchester
<input type="checkbox"/>	Edgefield
<input type="checkbox"/>	Fairfield
<input type="checkbox"/>	Florence
<input type="checkbox"/>	Georgetown
<input type="checkbox"/>	Greenville

<input type="checkbox"/>	Greenwood
<input type="checkbox"/>	Hampton
<input type="checkbox"/>	Horry
<input type="checkbox"/>	Jasper
<input type="checkbox"/>	Kershaw
<input type="checkbox"/>	Lancaster
<input type="checkbox"/>	Laurens
<input type="checkbox"/>	Lee
<input type="checkbox"/>	Lexington
<input type="checkbox"/>	McCormick
<input type="checkbox"/>	Marion
<input type="checkbox"/>	Marlboro
<input type="checkbox"/>	Newberry
<input type="checkbox"/>	Oconee
<input type="checkbox"/>	Orangeburg
<input type="checkbox"/>	Pickens
<input type="checkbox"/>	Richland
<input type="checkbox"/>	Saluda
<input type="checkbox"/>	Spartanburg
<input type="checkbox"/>	Sumter
<input type="checkbox"/>	Union
<input type="checkbox"/>	Williamsburg
<input type="checkbox"/>	York
<input type="checkbox"/>	Statewide

## Pre-Contractual Information Form

Have you ever worked for an agency that has received Medicaid funds? \_\_\_\_\_

If yes, what agency and what was your position? \_\_\_\_\_

---

Have you have ever been an enrolled or contracted Medicaid provider?

If yes, when (dates) \_\_\_\_\_ Which state? \_\_\_\_\_ What service did you provide? \_\_\_\_\_

What was/is your previous/current Medicaid provider number? \_\_\_\_\_

Are you currently enrolled or contracted with DHHS for any service provision? \_\_\_\_\_

If not, when did contract or enrollment end? \_\_\_\_\_

If terminated, was termination voluntary or involuntary? \_\_\_\_\_

If this is an agency or corporate entity, has the agency ever been enrolled or contracted with Medicaid? If yes, when? (dates) \_\_\_\_\_ Which state? \_\_\_\_\_

What type of service was provided? \_\_\_\_\_

---

What was/is the agency's or corporate entity's previous/current Medicaid provider number? \_\_\_\_\_

Have any officers, agents or employees been terminated, been denied participation in the Medicaid Program or denied a contract with DHHS? \_\_\_\_\_

If yes, when? (dates) \_\_\_\_\_ For what service? \_\_\_\_\_  
Reason? \_\_\_\_\_

---

*Any falsification of information submitted is grounds for denial or termination of a contract.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**SAMPLE ORGANIZATIONAL CHART**

President

Name: \_\_\_\_\_

Chief Executive  
Officer

Name: \_\_\_\_\_

Chief Financial  
Officer

Name: \_\_\_\_\_

Chief Operations  
Officer

Name: \_\_\_\_\_

Supervisor

Name: \_\_\_\_\_

Supervisor

Name: \_\_\_\_\_

Supervisor

Name: \_\_\_\_\_

Supervisor

Name: \_\_\_\_\_

Supervisor

Name: \_\_\_\_\_

Supervisor

Name: \_\_\_\_\_

\*This chart is only a sample and may not apply to the organizational structure of your company.  
You may utilize this chart or create your own that more closely represents the organizational structure of your company.